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Project SAFE
A Developmental Model of Recovery

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Early Project SAFE reports raised a number of theoretical questions about the nature of addiction and recovery in women, and called for the construction of a research-grounded developmental model of recovery that could illuminate the styles and processes of addiction recovery among Project SAFE clients. In the absence of quantitative research data, stories and perceptions about stages in the recovery process for SAFE women were solicited from child welfare workers, outreach workers and treatment staff at all of the SAFE sites. This qualitative data was then organized into a beginning conceptualization of the stages of change experienced by most women involved in this project. This brief paper represents an attempt to provide a theoretical framework from which the recovery of Project SAFE women can be understood and from which interventions can be strategically selected and appropriately timed.

Recovery as a Developmental Process

There are a number of key propositions central to a developmental model of addiction recovery. Those most crucial to organizing the experience of women in Project SAFE include the following:

- Addiction recovery, like the active process of addiction, is often characterized by predictable stages and milestones.
- The movement through the stages of recovery is a time-dependent process.
- Within each stage of recovery are developmental tasks, skills to be mastered, certain perspectives to be developed, certain issues to be addressed, before movement to the next stage can occur.
- The nature of the developmental stages of recovery are shaped by the characteristics of the individual; the nature, intensity and duration of drug use; and the social milieu within which recovery occurs.
- Developmental stages of recovery, while highly similar within subpopulations of addicts, may differ widely from subpopulation to subpopulation.
- Treatment interventions must be strategically selected to resolve key issues and achieve

mastery over key developmental tasks inherent within each individual's current stage of recovery.

- Treatment interventions appropriate to one stage of recovery may be ineffective or pose iatrogenic risks when utilized in another stage of recovery.

These propositions are consistent with the growing body of research on stages of change.

What follows is not a developmental model of recovery for women. The proposal of such a model would imply that women experiencing substance use disorders present with gender-defined and gender-shared problems that are unaltered by other dimensions of individual character and experience. Such a model would also imply that there is a shared developmental trajectory (a singular pathway) of recovery for all women and that there exists a narrowly proscribed treatment technology to provide guidance through this developmental process. What follows is a developmental model of recovery for *persons* who share certain experiences and characteristics. There are many women for whom this model would not apply and many men for whom it would. The fact that more women than men share the core characteristics defined below is a function not of gender biology but of the social, economic and political oppression within which women are born and within which they must seek their individual destinies.

The Core of Shared Experiences and Adaptations

The developmental trajectory of addiction recovery is shaped by the totality of experiences each person brings to the recovery process and, in particular, what each person brings by way of "recovery capital." Recovery capital is the total amount of internal and external resources a person can bring to bear on the initiation and maintenance of recovery (Granfield and Cloud, 1996). Populations for who share similar levels of recovery capital, similar assets and life experiences and circumstances, often share similar developmental processes of recovery.

Project SAFE women were often involved in a complex web of interlocking relationships (and problems) spanning several generations. The women who entered Project SAFE shared many experiences that shaped their perceptions of self, the self-drug relationship and the self-world relationship. It is impossible to understand the nature of addiction and recovery in these women without understanding the core experiences of their lives. Such core experiences include:

- Early and continuing losses
- Parental addiction and/or psychiatric illness
- Physical/sexual trauma
- Predatory social environments
- Recapitulation of family trauma in adult intimate relationships

When clinicians within Project SAFE compared the experience of SAFE women with the non-addicted women they had counseled who had not been involved in the abuse or neglect of their children, significant differences emerged. While women from both groups reported experiencing sexual abuse in childhood, the women of Project SAFE women reported an earlier age of onset of sexual abuse, multiple rather than single perpetrators of abuse, long duration of abuse (often measured in years), the presence or threat of physical violence as a dimension of the abuse, more boundary invasive forms of sexual abuse, and either being blamed or not believed when they broke silence about the abuse. What distinguishes Project SAFE women is not the occurrence of physical or sexual abuse or early childhood losses in their lives, events that many women experience, but the intensity and duration of these experiences.

Project SAFE clients tended to share both certain conditions and events in their lives and

certain meanings attached to these experiences. The experiences catalogued above created shared beliefs about themselves and the outside world. These beliefs became mottos for living and a major barrier to recovery:

- I am unlovable; I am bad.
- There is no physical or psychological safety.
- If I get close to people, they will die or leave me.
- My body does not belong to me.
- I am not worthy of recovery.
- Everybody's on the make; no one can be trusted.

Dependency as the Core Developmental Dimension for SAFE Women

In clinical staffings of Project SAFE women, the words “dependency, passivity, learned helplessness and learned hopelessness” were frequent refrains. It is our belief that shifts in this dependency dimension mark the essence of the developmental process of recovery for SAFE women.

In America, there is a deep paradox related to dependency. The culture highly values self-reliance and autonomy, but prescribes roles to women which inhibit self-assertion and encourage service and sacrifice to others. Women who most inculcate those values ascribed to women are branded as “pathologically dependent.” Women who challenge these values through self-assertion are often accused of somehow hurting their men, their children, their communities and their society. While most women experience some aspects of this cultural double-bind, some experience an intensified version of this self-dwarfing process. For the majority of women in Project SAFE, family of origin experiences began what became an escalating pattern of self-diminishing dependency upon people and things outside the self. Such patterns involve:

- An inability to state one's own wishes, needs, or ideas due to fear of conflict or rejection.
- A diminished capacity to define or assert one's own values and beliefs (to be self-directed).
- A severely diminished experience of self-legitimacy and self-value.
- An inability to pursue self-fulfilling, self-nurturing activities without fear and guilt.
- Achievement of esteem through identification with a person, group, or institution.
- A fear that life success or self-accomplishment will be followed by punishment or abandonment.
- An inability to initiate action to resolve one's own problems.
- A programmed preference for passivity, withdrawal and helplessness when confronted by problems and challenges.

We do not view such dependency patterns as inherent in the biology or character of women. We view such patterns as flowing from self-obliterating family and cultural systems. They are survival adaptations. They are strategies of self-protection. They are defenses against physical and psychological assault. Self-defeating patterns of dependency are highly adaptive, and passivity can serve as an alternative protective device to challenging and confronting family or cultural rules. Passivity and dependence often serve as homeostatic mechanisms within a marital/family system. Ego-sacrificing acts of women often serve to boost the egos of others.

This dependency dimension influences the manner in which these women must be engaged in the change process. Interventions, such as traditional confrontation approaches that heighten guilt and inadequacy, are misguided and harmful for this population. The dependency dimension influences the changing role of the treatment program staff in the long-term recovery

process. In the developmental stages outlined below, we have charted a progression from self-defeating dependence to healthy inter-dependence. The desirable and achievable goal of the change process extols not autonomy and self-reliance, but reciprocity and mutuality. This process is depicted as a movement from the denial and abuse of self to an affirmation of self within the context of mutually respectful intimate, family, and social relationships.

The Limitations of Stage Theory

In 1969, Elizabeth Kubler-Ross published her now classic work *On Death and Dying* in which she described five stages of grief and mourning (denial, anger, bargaining, depression and acceptance). Many counselors have for years used this theoretical framework to assist them in working with grieving clients. Used appropriately, this theoretical model has helped many clinicians both understand and mediate the healing process involved in traumatic loss. Applied to restrictively, this theoretical model has been misapplied by some clinicians to program the grief experience of clients for whom alternative styles of healing may be more naturally appropriate. Similarly, stages of change theories have been very popular in the addiction treatment field in recent years. But we have also used such models used to exclude clients (defining “pre-contemplative” clients as inappropriate for admission to treatment) rather than to enhance their readiness for change.

Models, as metaphors of collective experience, can be tools of empowerment for both clinicians and clients, particularly when the model fully embraces the experiences and needs of both. When a model doesn't fit the experience and needs of the client, its application can result in unsuccessful treatment or harmful treatment.

The construction of a developmental model of recovery for women in Project SAFE is an important milestone in the evolution of this project. It provides the theoretical foundation for what works and doesn't work in our interventions with these women and their families. It provides the framework that vindicates our movement outside the traditional boundaries of traditional theories and techniques to meet the needs of these women. The developmental model of recovery which follows should, however, not be viewed as a road map of recovery for all women, nor should the stages outlined be utilized as a prescriptive recipe whose ingredients and preparation procedures must always be the same. Our model is a road map that has utility only when it precisely reflects the clinical terrain within which we are working. When this terrain changes via core characteristics and experiences of women in Project SAFE, then the model should be adapted or discarded.

In our observation of and involvement with Project SAFE women over the past sixteen years, we have seen six identifiable stages in the movement from addiction to stable recovery. These stages and the roles helping professionals can play in each stage are described briefly below. The stages are a composite of what we have seen with Project SAFE women. Some women skipped certain stages. Others varied the sequence. Still others went through several cycles of these stages during their SAFE tenure. The stages overlap and there are not always clear points of demarcation separating one from the other. For example, early stage issues of safety and trust don’t completely dissipate. They simply require less emotional effort as the ever-present roar of “don't trust” subsides to a whisper.

Stage 1: Toxic Dependencies

If there is any phrase that captures the pre-treatment status of Project SAFE women, it is “toxic dependencies.” They bring dependencies on alcohol, cocaine, heroin and other psychoactive drugs that have interfered with many areas of their lives. They exhibit a propensity to involve themselves in toxic, abusive relationships with men and women. They also exhibit a propensity to involve themselves in toxic relationships with “enabling institutions” whose effect is to sustain rather than break this larger pattern of dependency. The Project SAFE client has

little sense of self outside these dependent relationships with chemicals, people and institutions.

The themes of death, loss, abandonment, and violation of trust in her life are constants that progressively diminish self-respect and self-esteem. Whether manipulated through nurturing or through violence, she has learned that the world is a predatory jungle in which physical and psychological safety is never assured. Out of self-protection, a secret self is created and encapsulated deep within this woman. She protects and hides this self from exposure to outsiders. Her true self can never be rejected because it will never be revealed. Sealed in fear and anger, this secret self becomes so deeply hidden that the woman herself loses conscious awareness of its existence.

The locus of control during active addiction is increasingly of external origin. Her relationship with drugs cannot be internally controlled by acts of will or resolution. Her relationships with others are marked by inconsistency and unpredictability of contact. Everything in her life seems to be shaped by outside forces and persons. By the time a woman comes in contact with Project SAFE, the power to shape her own destiny has been obliterated by the chaos of her life. Her life is buffeted by the conflicting forces of her drugs, her drug using peers, her family, her intimate partner, and a growing number of social institutions closing in on her lifestyle.

Amidst this backdrop of chaos, she slides into increased passivity, increased hopelessness and helplessness and increased dependence on drugs and toxic relationships. There is pain in great abundance, but insufficient hope to fuel sustained self-assertion into recovery. “Powerlessness” for this woman is a fact of life, not a clinical breakthrough. The spark that can ignite the recovery process must come from without, not within. For social agencies to wait for this woman to “hit bottom,” in the belief that increased pain will motivate change is delusional and criminal. Where the internal locus of control has been destroyed, the client can “live on the bottom,” having lost everything short of her own life, and still not reach out for recovery. It is not a shortage of pain, but a shortage of hope and a lost capacity to act, that serve as the major obstacles to change. More potential sources of external control eventually emerge through crises related to homelessness, acute medical problems, arrest, victimization by violence, or through the abuse and/or neglect of her children.

Family of origin relationships are quite strained for SAFE women. Family members either share the client's lifestyle or have disengaged out of discomfort with the client's drug use and lifestyle. And yet, family members may be pulled back in during episodes of crisis to take rescuing action on behalf of the client. The social worlds vary for SAFE women. Some are socially isolated, enmeshed in a solitary world of drug use surrounded only by a few primary relationships with active users or persons who support, via enabling, their continued drug use. Other SAFE women are deeply enmeshed in a culture of addiction, an exciting world of people, places and activities all of which reinforce sustained drug use. The drugs and the roles and relationships in the culture of addiction all hold out the promise of pleasure and power but alas, as a metaphor for her life, bring betrayal in the form of pain and loss.

The etiology of the neglectful/abusive behavior exhibited by the SAFE client toward her children springs from multiple sources: the emotional deficits and debilities resulting from her own family of origin experiences, the lack of appropriate parenting skills, environmental chaos that competes with parenting responsibilities, increased loss of control over the drug relationship, and sustained exposure to a predatory drug culture. She constitutes the ultimate paradox of motherhood. Scorned and shamed by those who don’t know her (“How could a mother neglect her child because of a drug?”), her desire to remain the mother of her children will remain the primary external force that sustains her through the change process.

In short, the woman who will come in contact with Project SAFE is compulsively involved in dependent relationships with abusable substances and abusing people, lives in environments that are chaotic and traumatizing, and is constitutionally incapable of a self-initiated, spontaneous break in this dependent lifestyle. All of her experiences have confirmed that the world is a physically and psychologically dangerous place. Her contacts with helping

professionals during this stage are likely to be marked by passive compliance (role playing) or by open disdain and distrust.

There is, however, as much strength in this profile as pathology. The ultimate pathology is the environmental pathology which demanded that SAFE women sacrifice their esteem and identity as an act of survival. While the consequences of these adaptations may appear as pathological personality traits to those unfamiliar with such traumatizing environments, seen from another perspective, these are stories of survival and incredible resiliency. The strength inherent in sheer survival is the seed from which the recovery process will eventually sprout. That seed must be acknowledged, nurtured and channeled into the change process.

Stage 2: Institutional Dependency

The initiation of sobriety and the period of early recovery for SAFE women is marked by decreasing dependence upon drugs and unhealthy relationships, and an increasing dependence upon Project SAFE staff and the institution within which it is nested. Stage 2 is marked by the following three phases: 1) testing and engagement, 2) stabilization, and 3) reparenting.

Rarely if ever do Project SAFE women present with a high level of motivation for change. The earliest stage of engagement is usually induced by external fiat (court mandated treatment or fear of losing children) or through the persistence of an outreach worker. Whether presenting with superficial compliance or open hostility, the engagement period is a ballet of approach-avoidance and ambivalence. The tipping of the scales are often shaped by the relative interactions of hope and pain. There is a hope-pain synergism (illustrated below) that dictates the outcome of our efforts at engagement.

The Hope-Pain Matrix

High Pain HP	Low Hope LH	HP-LH most typical initial pattern encountered with SAFE women. External control and hope-engendering relationships key ingredient to treatment engagement
High Hope HH	Low Pain LP	HH-LP represents honeymoon phase in drug relationship. Drug relationship experienced as solution rather than problem. Poor treatment success; high risk of relapse.
HP-HH produces high internal motivation and rapid engagement in treatment. Good treatment prognosis.	LH-LP represents post-honeymoon phase of drug relationship. Trust building by OR workers can set stage for treatment engagement during crisis.	

Where there is high pain and high hope, a rarity, engagement can be quick and intense. Where there is low pain and low hope, there is minimal chance of treatment initiation. It is in the combinations of high pain and low hope and high hope and low pain, that the intervention technology of outreach can work its magic of persistence and consistent positive regard to alter the equation to get treatment engagement. (See Chapter Six for a discussion of this technology.)

The earliest relationship between SAFE women and the treatment milieu is one of great ambivalence. Clients maintain a foot in both worlds (addiction and treatment) gingerly testing each step forward and backward. In this transition period can be found enormous incongruities and contradictions, e.g., clients who want to keep using drugs AND keep coming to treatment, clients who want staff to go away because staff make them feel good and hopeful. While this ambivalence may have its subtleties, it is most often played out behaviorally in dramatic fashion, e.g., missed days of treatment attendance, splitting in anger and then calling to seek reconciliation, relapse behavior, etc. True emotional engagement is rarely a bolt of lightning event. It is much more likely to be a slow process of engagement with every stage marked by testing behaviors.

The earliest experiences of positive regard and hope experienced by Project SAFE women can trigger strong counter reactions. The woman who too quickly reveals her secret self may react in anger (temper tantrums) or in flight (missed meetings). The hope-instilling positive regard from SAFE staff may escalate a client's self-defeating patterns of living, e.g., setting others up to reject her as a confirmation of her life positions that trust is foolish and nowhere is safe. When staff refuse to be driven back by these exaggerated defense structures, the client is forced to experience herself differently and to rethink her beliefs about herself and the world. This testing, experiencing acceptance and rethinking process may go on in its most intense forms for weeks before a woman fully commits herself to the SAFE program. For women who get through this initial stage, testing may resurface later during critical developmental milestones in the recovery process. For women who cannot resolve this trust/safety issue, their drug using lifestyle will continue unabated.

In the stability phase, outreach and case management services provided through project

SAFE have reduced the environmental chaos (housing, transportation, legal threats, etc.) to manageable levels and overall treatment efforts have created an initial (but still fragile) emotional bond between the client and the treatment team. As external threats to safety and survival subside, the Project SAFE client begins to master the personal and social etiquette of SAFE participation, e.g., regular attendance, group participation, etc. As soon as sobriety and environmental stability begins, emotional thawing and volatility escalates.

This can be a stage of raw catharsis. Pent-up experiences unleash powerful emotions when first aired to the outside world through storytelling. With the experience of safety, clients can begin peeling away and revealing layers of the secret self only to discover dimensions that were unknown even to themselves. Healing of this pain will occur in levels through all of the stages described in this model. At Stage 2, the most crucial dimension is the experience of acceptance by others following self-disclosure. There is, at this stage, a sense that shared pain is diminished pain, and that secrets exposed to the light of disclosure lose their power to haunt and control.

There are several dimensions of reparenting within Project SAFE spread over the developmental stages of recovery outlined here. At this early stage, Project SAFE takes over a parental role with project clients, tending to issues of survival and safety. It is a nurturing, "doing for" process. At an emotional level it involves experiencing unconditional "thereness" -- the consistent physical and emotional presence of the program in the life of the client. It involves the experience of consistency, a non-voyeuristic and non-judgmental openness to their life stories, and the ability to tolerate testing, but still set limits. It is the experience that one can mess up, but not jeopardize one's status as a family (SAFE) member. As clients become more receptive to this emotional nurturing, they may regress and become quite dependent upon the program. This escalating dependence should be seen not in terms of pathology, but in terms of a developmental process of healing. It is through this increased dependence, and the needs that are being met through it, that the client begins to fully disengage from active involvement in the culture of addiction. The program must now meet all those needs which the client formally met within the society of addicts. The program must be available to fully fill this vacuum at this stage if contact with the culture of addiction is to be broken. Does that mean that a stage of "doing for" the client, a stage of consciously cultivating client dependence upon the treatment institution, is clinically warranted? YES!

Key developmental tasks that must be mastered by the client during Stage 2 include:

- Resolving environmental obstacles to recovery.
- Working through the ability to maintain daily sobriety.
- Relationship building with staff that transcends stereotyped role behaviors of "client" and "professional helper" (movement beyond compliance).
- Learning etiquette of program participation.
- Breaking contact and asserting isolation from culture of addiction.
- Exploring limits of safety in the treatment environment via storytelling and boundary testing.
- Accepting nurturing from project staff.
- Verbalizing, rather than acting out, compulsions of fight or flight.

During Stage 2, clients still have little sense of personal identity. Where identity in Stage 1 was formed through identification with a drug, a drug culture, and a small number of highly abusive relationships; identity in Stage 2 comes through drug abstinence, identification with a treatment culture, and a small number of highly nurturing relationships. Denial dissipates during Stage 2 and personalized talk about alcoholism/addiction reflects the growing recognition of "addict" as an element of identity. Clients still need external sources of control over their behavior, although these sources begin shifting from negative (judicial coercion) to positive

(regard for relationships with staff).

Clients who get stuck in Stage 2 (and programs which conceive of Stage 2 as the terminal stage of treatment) contribute to the growing population of chronically relapsing clients who, fail to function either in the culture of addiction or in the society at large, become institutionalized clients in the substance abuse treatment system.

Stage 2 begins the reconstruction of the relationships between the SAFE mother and her children. With the resolution of environmental chaos, the initiation of sobriety, and early engagement in treatment, the most dysfunctional aspects (neglect and abuse) of the parent-child relationship have been addressed, but it may be some time before quality parenting will appear. Early recovery parenting efforts often reflect a lack of basic parenting skills and efforts to compensate for guilt related to past drug-related deficiencies in parental effectiveness, e.g., overprotection or overindulgence. As the mother herself experiences re-parenting in relationships with staff, she becomes more empowered to mirror these experiences with her children, e.g., feedback, nurturing, boundary setting, problem solving, etc.

Stage 3: Sisterhood

In Stage 3, relationships of mutual respect and trust established between the client and the Project SAFE staff begin to be extended to encompass other women clients in the SAFE project (one's treatment peers). The earliest efforts in these peer to peer relationships are marked by diminished capacity for empathy, the inability to listen to another with the roar of one's own ego in check, the lack of social etiquette, and the need to clearly proscribe the limits of trust. Clients speak at the same time, fail to respond emphatically to painful self-disclosure, make commitments to each other that are broken, react to feedback with verbal attack or threats of violence or flight, etc. It is the treatment milieu that must provide the skill development and the relationship building processes to weld these disparate individuals into a mutually supportive group.

Over time, clients begin to extend their trust and dependence upon staff to a growing reliance on the help and support of their treatment peers. Within the structure of the treatment milieu, they move from the position of "none can be trusted" to a realistic checking of who can be trusted and the limits of that trust. The early friendships between treatment peers constitute the embryo of what will later be a more fully developed culture of recovery. As skills increase, the client learns to not only speak, but to listen; to not only receive feedback, but to offer feedback; to not only receive support, but to give support. It is crucial that treatment staff provide permission and encouragement for decreased dependence upon staff and increased dependence on other health-enhancing relationships within and beyond the treatment milieu.

The peer milieu is an important vehicle through which Project SAFE women wrestle with some of their most troublesome treatment issues. This is the milieu within which sexual abuse and other family of origin pain is explored. It is here that they can grieve their many losses. This is the arena within which abusive adult relationships are mutually confronted. This is the arena in which clients come together collectively to fight back against shame and stigma to restore their honor and self-respect both as women and as mothers.

During this stage, there is an intense exploration of victimization issues. Stories of victimization are shared. Catharsis of pain and anger is achieved. A "sisterhood of experience" is achieved. Early identity reconstruction focuses on victimization issues. Individual and collective identity focuses heavily on what has been done to them. Projection is the dominant defense mechanism. The client sees herself in trouble due to persons, institutions and circumstances over which she has no control. It will be some time before this focus can shift to her responsibilities, her choices, her role in her current life position.

Key developmental tasks that must be mastered during Stage 3 include:

- Extension of self-disclosure to treatment staff to treatment peers.
- Early relationships with recovering role models encountered within the treatment site.
- Exploration of victimization issues.
- Rapid expansion of social skills (parallels period of early adolescent development).
- Treatment agency focused lifestyle develops as alternative to culture of addiction.
- Shift in relationships from drug-oriented to recovery-oriented.

Stage 3 is the first time SAFE clients begin to experience themselves as part of a broader community of recovering women. Identity and esteem are increasingly based on identification with this community. The shift in identity from “addict” to “recovering addict” marks a beginning stage in the reclamation of the self. These shifts in identity are not without their risks as we shall see in the next Stage.

Major risks of relapse during Stage 3 come from panic, secondary to emotional self-disclosure, relationship problems between treatment peers, and failure to sever or reframe past drug-oriented intimate and social relationships.

Stage 4: Selfhood and Self-help

Where Stage 3 focused on shared experiences, SAFE clients in Stage 4 begin some differentiation from the treatment group. There is more focus on personal, as opposed to collective experience. The “victim” identity diminishes during this stage and there is a greater focus on self-responsibility. This stage involves an exploration and expiation of emotion surrounding one’s own “sins” of commission or omission. Treatment time shifts from what “they” did to what “I” did. There is a confessional quality to early work in this stage with, self-forgiveness being a critical milestone. There is, for the first time, a shift in focus from personal problems to personal aspirations. This stage marks the beginning reconstruction of self that will continue throughout the lifelong recovery process.

In Stage 4, Project SAFE women begin to experiment with the development of health-enhancing relationships outside the treatment milieu. Having developed some sense of safety and identity within the treatment milieu, they seek to extend this to the outside world by finding networks of long-term support. The two most frequent structures utilized by Project SAFE clients for such support in Stage 4 are self-help groups and the church. This is a critical stage through which the emotional support the SAFE client has received from treatment staff and treatment peers is extended for the first time to a broader community beyond the treatment site. There is also a focus on rebuilding strained or ruptured family relationships during this period. With sustained sobriety and program involvement and obvious changes in her lifestyle, estranged family members once again open themselves to re-involvement with SAFE clients.

Self continues to be defined in Stage 4 through external relationships. A period, perhaps even a sustained period, of extreme dependence upon this support structure, while criticized by persons not knowledgeable about the developmental stages of recovery, can be the critical stage in the movement towards long-term recovery. During this period, the client's whole social world may be shaped within the self-help or religious world. This period constitutes a period of decompression from the toxicity of the culture of addiction and a period of incubation within which the self and self-world relationship are reconstructed.

If the shift in dependence from the treatment milieu to outside supports is made too quickly, the client will experience this encouragement for outside relationships as abandonment by the treatment staff. Traditional short-term treatment models that encourage this shift at a very early stage in recovery may inadvertently recapitulate the client's fear and experience of loss and abandonment. In Project SAFE, we found that these relationships needed to supplement, rather than replace, those primary relationships of support within the treatment milieu.

There is a reassessment and decision point during Stages 3 and 4 as whether to move forward in the recovery process or to retreat back into the world of addiction. During these stages, the full implications of the recovery lifestyle become clear. There is fear that long term recovery is still not a possibility. There is fear of the future unknown and their ability to handle it. As bad as the past is, it continues to exert its seductive call as a world they know better than any other. If treatment contact and support is prematurely ended during this stage, relapse is likely.

Stage 5: Community Building

In Stage 5, SAFE women extend their system of supports into the broader community. It is at this stage that clients must figure out how to maintain sobriety while fully living in the world. It is a stage of lifestyle reconstruction. Friendships that are based neither on active addiction nor shared recovery are explored and developed. The earliest activities within this stage may begin very early or very late in the recovery process. For SAFE women, the earliest activities are often initiated via outreach workers. Tours of community institutions, getting a library card, going on picnics, bargain hunting at garage sales and flea markets, and experimenting with drug-free leisure may all be aspects of community building initiated through the treatment experience. A major aspect of Stage 5 is the establishment of drug free havens and drug free relationships that can nurture long-term recovery. Another aspect of this stage is the repositioning of the family in the community, re-establishing old healthy linkages to community institutions and building new linkages.

It is important that treatment staff possess a sensitivity to non-traditional pathways to recovery. Many recovering women may set the roots of their recovery in institutions other than traditional self-help groups. The church served as a primary support institution to many SAFE women, either as an adjunct or an alternative to traditional addiction self-help groups.

The parenting of SAFE mothers changes in a number of ways during these later stages of recovery. Earlier stages set the groundwork through the acquisition of basic parenting skills and working through stages of overindulgence and overprotection. The emotional needs of the mother are so intense early in the recovery process, that it is very difficult for her to maintain a sustained focus on the needs of her children. In Stage 5, however, the intensity of these internal needs have been addressed to allow for a much richer quality in the relationship between the client and her children. Where she achieved consistent physical presence in earlier stages of recovery, she now creates a consistent emotional presence in the life of her children.

There is also a shift in Stage 5 in the relative health of the client's intimate relationships. Abusive relationships which may continue into the early stages of recovery have now been changed or severed. Some, at this stage, will have gone through experimentation with a variety of relationships, some will have found a primary long-term relationship, while others may find themselves content for the time being to seek their destiny without the security or burden of a primary relationship.

Stage 6: Interdependence

Stage 6 in the developmental progression of recovery for SAFE women, constituted not by a fixed point of achievement, but entry into a lifelong process of doubt, struggle, and growth. The shift from the earliest stages is one from self-negating dependence to self-affirming inter-dependence. This stage is marked by the emergence and continued evolution of an identity that transcends both the addictive history and the history of involvement with helping institutions. In a literal sense, this self-emergence is really not a "recovery" process, since recovery implies a recapturing or retrieval of something one once had. This is not retrieval of an old self; it is the creation of a new self. It is more a process of "becoming" than a process of "recovering."

Due to the lack of long-term follow-up studies of Project SAFE, we don't know a lot about this stage of recovery for SAFE women. We do have inklings of some of the elements within this

stage as more and more women stay in touch with the staff over a period of years. It seems to be marked by:

- Movement toward one's personal aspirations, often reflected in achievement of some personal milestone, e.g., completing high school, getting into college, and gaining employment.
- Working through the tendency to substitute drugs with other excessive behaviors, e.g., workaholism, food, and sex.
- A maturing out of the narcissistic preoccupation with self that characterized active addiction and the early stage of recovery.
- The creation of a social network in which relationships are characterized by mutual respect and support.
- The organization of one's life around a set of clearly defined values and beliefs.
- The emergence of acts of service to other people (including, for some, coming back years later to work as outreach workers in Project SAFE).

There is tremendous diversity in how women within Project SAFE have experienced, or failed to experience, the recovery process. For some, sobriety and the enhancement of parental functioning were introduced into an otherwise unchanged life. For others, Project SAFE would represent the beginning of a life-transforming recovery process. It is our hope that this paper has captured some of the shared experiences that transcend this diversity.